to a similar degree 20 minutes after administration, but at 2 hours only cromolyn sodium was still more effective than a placebo.[1] At twice the manufacturers' recommended doses nedocromil sodium (8 mg) and cromolyn sodium (4 mg), administered via metered-dose inhaler, had comparable efficacy in inhibiting exercise-induced asthma.[2]

We also agree that nedocromil sodium seems to have a good safety profile; however, 13.6% of patients taking it report a "bad taste," 4.8% headache, 4.0% nausea, 1.8% vomiting and 1.2% dizziness.[3,4] In contrast, cromolyn sodium administered via metered-dose inhaler or nebulizer solution seldom elicits complaints about bad taste or other adverse effects.[5,6]

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The ter Neuzen case: impossible standards

I learned most of what I know about the tragic case of Kobe ter Neuzen, the nurse infected with human immunodeficiency virus (HIV) during artificial insemination, from the article "AIDS court case could lead to higher costs, CMA spokesman warns," by Elizabeth Godley (*Can Med Assoc J* 1992; 146: 227-231).

Mascola's letter to the *New England Journal of Medicine* in October 1983 raised the possibility of HIV transmission through artificial insemination.[1] An Australian immunologist confirmed the possibility in November 1984 and published an article about it in September 1985.[2] Ter Neuzen was infected on Jan. 21, 1985, before the publication of any evidence of risk. The physician who did the insemination, Dr. Gerald Korn, appears to have acted responsibly by notifying his patients in October 1985.

It would be wrong to accept and disseminate theories immediately. Moreover, not everyone reads or should read the *New England Journal of Medicine*. Furthermore, there is no reference in Godley's article to any mention of the risk of HIV transmission through artificial insemination in the expert journals with which Korn should be familiar.

Donald Casswell, associate dean of law at the University of Victoria, applauds the jury's decision, but it is unclear why this "will perhaps give courage to other people who are HIV infected and encourage them to come forward."

I am also concerned by the remark of the CMA's then director of communications, Doug Geekie: "There's an avalanche of new facts coming out all the time and the task of trying to keep abreast of it is quite impossible." This is rendering an apology for physicians when none is required.

Perhaps information from sources other than this article would enlighten readers further. However, if the essence of what is reported is correct we should question how adequately Korn was defended. Ter Neuzen's suffering justifies neither the tragedy for a "respected and well-established" physician nor the need for all Canadian physicians to be held to impossible standards.

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Is it time to close your hospital's ER?

Dr. Stirling Sublett (*Can Med Assoc J* 1991; 145: 1489-1492) accurately voices the concerns expressed by many in response to the Ontario Ministry of Health's *Guidelines for Hospital Emergency Units in*

Ontario. In addition, he highlights the difficulties encountered in providing a consistent minimum standard of care in Ontario's 199 emergency departments, as evidenced by the apparent lack of uniformity in the response to the government's follow-up survey.

Despite the ministry document's imperfections, the Canadian Association of Emergency Physicians (CAEP) welcomes it as a positive initiative that delivers a challenge to the status quo. At the least, the guidelines have provided a necessary impetus for much-needed introspection and review by hospital boards, administrators and health care workers as they measure their own situations against a standard. The ensuing discussion and debate can only be considered healthy and for the public good (although it is regrettable that the ultimate benefactor of this review, the consumer, was largely excluded from the process.) CAEP is in favour of similar initiatives on a national basis.

One particularly disturbing feature of the guidelines and the subsequent survey deserves comment. There is a feeling in Ontario that the Ministry of Health has a "hidden agenda": an as yet unstated consequence of potential closures of emergency departments and rationalization of services where the guidelines are not met.

Such closures may sometimes be entirely appropriate, particularly in smaller communities that have two hospitals within reasonable proximity providing similar emergency services. It may not be appropriate, however, in rural communities, given the realities of Canadian geography, manpower shortages and limited access to acute care.

CAEP would rather see these rural emergency departments strengthened and supported through emphasis on a systems approach to the delivery of emergency care in Canada, improved undergraduate and prelicensure training in emergency medicine for all physicians, enhanced opportunities for continuing education in emergency medicine for physicians who have made the commitment to provide acute care services for their communities and an improved manpower database to facilitate system design and funding of postgraduate training programs.

Sublett, despite his initial concerns, ultimately accepts the concept of a minimum standard of care, citing the Ontario public's right to expect a "quality product" when they present to an emergency department. CAEP agrees with his conclusion. It is time to embrace the future and move forward so that all Canadians can be given the same assurance.

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Funding in the asbestos debate

A recent issue of *CMAJ* published letters by Dr. J. Bernard L. Gee (1992; 146: 14-15) and Dr. Keith Morgan (*ibid:* 15-16) written in response to an editorial by Dr. David V. Bates, "Asbestos: the turbulent interface between science and policy" (*Can Med Assoc J* 1991; 144: 554-556).

As a founder and former treasurer of Collegium Ramazzini and a participant in the regulatory policy debate on asbestos, I am obliged to clarify some issues raised in these letters.

There is nothing mysterious or nefarious about the court grant received in support of our 1990 New York conference on asbestos, to which Morgan refers. He may have some difficulty with the way our common language is used in the United States, but he should feel comfortable with definitions in the 1971 edition of the *Oxford Dictionary*: a court is "the place, hall, or chamber in which justice is judicially administered"; a grant is "a gift or assignment of money, etc. by the act of an administrative body or of a person in control of a fund or the like." It was in a court that money was granted to us from a fund controlled by a judge. The source of the grant is on record in public files and is available to the defendants' attorneys, who informed Morgan for the purpose of denigrating Bates's editorial.

Yes, partial support for the conference was received in the way of a grant from the plaintiffs' attorneys, who were interested in the debate of scientists in a public forum. The debate was of the same kind we held in Ottawa on the same issues in 1988. In both Ottawa and New York we invited representatives from all sides of the issue and presumably neutral public officials as observers. Both meetings were supported by money from defendants' attorneys and even press agents of Canada's Asbestos Institute. Our meetings are never funded entirely by any one set of partisans.

The purpose of the collegium is to build a bridge between the worlds of science and public policy. We cannot achieve that purpose by talking only to ourselves or other scientists. Given the high judicial interest in asbestos in our country it was appropriate to make a special effort to invite to the New York meeting judges who otherwise are exposed only to the expert witnesses brought in by the contesting attorneys. We did our best to reduce the cost of their attendance to create opportunities for a broader purview of the issues. We succeeded.

Gee and the authorities he references on the issues of risk